






A Healthier Tomorrow Starts Today

CALL TOLL-FREE, 1-800-880-5305

Use This Mail-In Application To Apply For

MEDI-CAL FOR CHILDREN

No-Cost Health Coverage for Children, Birth Through Age 18, and Pregnant Women

- No-cost comprehensive health, dental and vision benefits for children.
- No monthly premiums.
- No copayments for any benefit.
- Choice of health insurance plans in most major population centers.
- Family property (such as savings or cars) does not count for eligibility.
- More children with higher family incomes qualify for **no-cost Medi-Cal**.
- Available for children of single or two-parent working families.
- Mail-in application. Does not require a visit to the welfare office to apply.

HEALTHY FAMILIES

Low-Cost Health Coverage for Children Birth Through Age 18

- Low-cost comprehensive health, dental and vision insurance.
- Low monthly premiums from $4 per child to a maximum of $45 per family.
- No copayment for preventive services (such as immunizations). $5 copayment for non-preventive services (such as going to the doctor due to illness).
- Choice of health, dental and vision insurance plans.
- Family property (such as savings or cars) does not count for eligibility.
- For children without health insurance and children on **Medi-Cal with a cost**.
- Available for children of single or two-parent working families.
- Mail-in application.
- Apply up to 3 months in advance for an unborn child, or a child who will turn 1 or 6 years old and lose **no-cost Medi-Cal**.

Medi-Cal and Healthy Families are two health care programs:

- Family size, age of the child and income determine which program a child may qualify for. A younger child may qualify for **no-cost Medi-Cal** and an older child may qualify for **Healthy Families**.
- If the child qualifies for **no-cost Medi-Cal** he/she **does not qualify** for **Healthy Families**.
- If your income is too high to be eligible for **no-cost Medi-Cal**, your **child may qualify** for **Healthy Families**.

To be eligible for Medi-Cal or Healthy Families using this form, a person must be:

- Under age 19, or a pregnant woman
- Within income guidelines
- A California resident
- A U.S. citizen, national or eligible alien. Regardless of immigration status or date of entry, a child or pregnant woman can qualify for some form of **Medi-Cal**.

MC 321 HFP (rev. 04/06)
INSTRUCTIONS

HOW TO APPLY:

To apply, you **do not** have to figure out what program(s) the child or pregnant woman is eligible for.

- Just fill out application pages A1-A3 and mail it with all required documents.
- If it appears your child is eligible for **Healthy Families**, you may also fill out page A4. Mail all 4 pages (A1-A4), with a premium payment and all required documents. You can do this now or we will contact you after we determine your child is eligible. If you fill it out now, coverage will start sooner.
- Even before you know if your child qualifies for **Medi-Cal**, you can call 1-800-430-4263 (the call is free), to find out about health plans that are available in your area and to ask for an informing packet with enrollment forms.

DO YOU NEED HELP? ALL HELP IS FREE!

If you want to know which program you qualify for **before** you sign and submit your application, or you need help completing the application, call us **toll-free, 1-800-880-5305**. Our operators can also give you the name and telephone number of a trained Certified Application Assistant in your community.

GROSS MONTHLY INCOME *(EFFECTIVE APRIL 1, 2006)*

You do not have to know which program your child may qualify for, but you can use the chart below if you want an idea. If your family's monthly income is at or below the amount shown, your child may qualify for **Healthy Families** or **no-cost Medi-Cal**. If you work, pay for child care, or pay/receive child support and/or alimony, we will reduce the family's income level. Family income, family size and allowable deductions are explained throughout these instructions. For information about larger families, call us **toll-free, 1-800-880-5305** or ask a **Certified Application Assistant**.

FAMILY SIZE	CHILD BIRTH UP TO AGE 1 OR PREGNANT WOMAN MEDI-CAL	CHILD BIRTH UP TO AGE 1 HEALTHY FAMILIES	CHILD AGE 1 THRU 5 MEDI-CAL	CHILD AGE 1 THRU 5 HEALTHY FAMILIES	CHILD AGE 6 THRU 18 MEDI-CAL	CHILD AGE 6 THRU 18 HEALTHY FAMILIES
1	$0 - $1,634	$1,635 - $2,042	$0 - $1,087	$1,088 - $2,042	$0 - $ 817	$ 818 - $2,042
2	$0 - $2,200	$2,201 - $2,750	$0 - $1,463	$1,464 - $2,750	$0 - $1,100	$1,101 - $2,750
3	$0 - $2,767	$2,768 - $3,459	$0 - $1,840	$1,841 - $3,459	$0 - $1,384	$1,385 - $3,459
4	$0 - $3,334	$3,335 - $4,167	$0 - $2,217	$2,218 - $4,167	$0 - $1,667	$1,668 - $4,167
5	$0 - $3,900	$3,901 - $4,875	$0 - $2,594	$2,595 - $4,875	$0 - $1,950	$1,951 - $4,875
6	$0 - $4,467	$4,468 - $5,584	$0 - $2,971	$2,972 - $5,584	$0 - $2,234	$2,235 - $5,584

APPLICATION INSTRUCTIONS

SECTION 1

Tell us about the person applying for the child, the pregnant woman, the unborn child, or him or herself.

Question 16

We encourage you to take advantage of health care for your children regardless of which program they qualify for.

- **Children**: We will enroll your child in the program he/she is eligible for unless you tell us not to. If you do not want your child enrolled in one of these programs, tell us by checking the box of the program you do not want. This means if you check the **Medi-Cal** box and your child is eligible for **Medi-Cal**, he or she will not get health care coverage from either program.
- **Pregnant Women**: The Access for Infants and Mothers (**AIM**) program provides health care to uninsured pregnant women whose income is too high to qualify for **no-cost Medi-Cal**. For more information and an application for **AIM**, call **1-800-433-2611**.

SECTION 2

Tell us about the children under 19 and/or the pregnant woman who want health coverage.

Answer Questions 17-32 for each child or pregnant woman wanting health coverage. If you are applying for an unborn child, check the box for unborn child under the **Child 1** column and tell us all the information you know at this time. Coverage for the unborn child will begin after **Healthy Families** receives documentation of the child's birth. To add more children, use a separate piece of paper or a photocopy of pages A1 and A2 of the application.

Question 18

Answer this question if it is different from the answer for Question 17.

Question 19

Write the complete address including Street Number and Name, Apartment Number, City and Zip Code, if different from Section 1.

Question 20

How is each child or pregnant woman related to the person in Section 1, Question 1. **For example:** daughter, spouse, stepchild, nephew, etc.

MEDI-CAL FOR CHILDREN

APPLICATION

Please use the instructions to complete this application.
Print clearly. Use black or blue ink only.

HEALTHY FAMILIES

TEAR HERE

SECTION 1: Tell us about the person applying for the child, the pregnant woman, the unborn child, or him or herself.

1 LAST NAME / FIRST NAME / MIDDLE INITIAL			2 BIRTHDATE MO / DATE / YR
3 HOME ADDRESS (NUMBER AND STREET). **DO NOT USE A P.O. BOX**		4 APARTMENT NUMBER	5 HOME PHONE # ( )
6 CITY	7 COUNTY	8 ZIP CODE	9 WORK PHONE # ( )
10 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX		11 APARTMENT NUMBER	12 MESSAGE PHONE # ( )
13 CITY			14 ZIP CODE
15A WHAT LANGUAGE DO YOU SPEAK BEST?		15B WHAT LANGUAGE DO YOU READ BEST?	

16 We will enroll the child or pregnant woman in the program they qualify for. If you do not want to be enrolled in one of these programs, check the box(es) below.

I DO NOT WANT:

- ❑ **Healthy Families**: Do not send birth certificates. Do not complete the Healthy Families Page.
- ❑ **Medi-Cal**

SECTION 2: Tell us about the children under 19 and/or the pregnant woman who want health coverage.

	Child 1 or Unborn (Check box ❑ if unborn)	Child 2	Child 3	Child 4	Pregnant Woman
17 Name: Last					
First					
Middle					
18 Name on Birth Certificate: Last *(If same as #17 above, leave blank.)*					
First					
Middle					
19 If the child's address is **not** the same as in Section 1, Question 3, give complete address:					
20 Relationship to person in Section 1:					
21 Sex:	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
22 Date of Birth:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
23 Place of Birth: County or State or Country, if outside the U.S.					
24 Ethnic Code: *(See #24 Instructions)*					
25 U.S. Citizen or National? If "no", please write date of entry into U.S.	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR
26 Social Security #:					

Social Security Numbers are not required for Healthy Families or for persons who want emergency or pregnancy related services only.

TEAR HERE

SECTION 2: Continued

	Child 1 or Unborn (Check box ☐ if unborn)	Child 2	Child 3	Child 4	Pregnant Woman
27 Mother's Name: Last					
First					
Does the mother live in the home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
28 Father's Name: Last					
First					
Does the father live in the home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
29 Name of teen's spouse or pregnant woman's husband: *(If living in the home)*					
30 Does any person(s) being applied for have **no-cost Medi-Cal**? If "yes", give date coverage ends/ended.	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR
31 Does the pregnant woman and/or children have other health, dental or vision insurance?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
32 Were any of the children insured by an employer in the last 90 days? If "yes", check the main reason why health insurance stopped and give the date it stopped.	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DAY YR

SECTION 3: Family members living in the home. Family size is taken into consideration when determining which program your children are eligible for.

33 List any other children living in the home under age 21 who are not listed in Section 2. Give their relationship to the person in Section 1, Question 1.

LAST NAME, FIRST NAME	RELATIONSHIP	LAST NAME, FIRST NAME	RELATIONSHIP

LAST NAME, FIRST NAME	RELATIONSHIP	LAST NAME, FIRST NAME	RELATIONSHIP

34 Are any family members who are living in the home pregnant? ❑ Yes ❑ No

If yes, who: ______________________ Date Due: ______________

35 List any stepparent living in the home not already listed: ______________________
LAST NAME, FIRST NAME

36 Do any of the people listed in this Section, or any of the parents listed in Section 2, want **Medi-Cal**? ❑ Yes ❑ No

TEAR HERE

SECTION 4: List the gross income (before taxes) of all persons listed in Section 2, Questions 17, 27, 28, 29 and Section 3 who live in the home. If self-employed or using federal income tax return to prove income, only complete Questions 37, 38 and 40 in this section.

37 NAME OF PERSON WITH INCOME	38 SOURCE OF INCOME?	39 HOW OFTEN RECEIVED?	40 HOW MUCH GROSS INCOME?	41 SOCIAL SECURITY # *(Optional)*
1.				
2.				
3.				
4.				

SECTION 5: Deductions from Family Income. The answers in this section will help determine what amounts will be deducted from your family's gross monthly income.

42 TYPE OF PAYMENT YOUR FAMILY MAKES	43 NAME OF PERSON WHO PAYS	44 MONTHLY AMOUNT PAID
Child Support		
Alimony		

45 CHILD CARE OR DEPENDENT CARE *(List child's name)*	46 AGE	47 MONTHLY AMOUNT PAID
1.		
2.		
3.		
4.		

SECTION 6: Other Coverage.

48 Has anyone filed a lawsuit because of an accident or injury on behalf of the pregnant woman and/or child applying for benefits? ❑ Yes ❑ No

49 Does the pregnant woman and/or child want to apply for **Medi-Cal** coverage for any medical expenses in the last 3 months? ❑ Yes ❑ No

If "yes", list month(s): _____

50 Check this box if you do not want **Medi-Cal** to share your child's application with the low-cost **Healthy Families** if your child no longer qualifies for no-cost **Medi-Cal.** ❑

SECTION 7: Voluntary Information. Not required. Your answers will not affect your eligibility but they will help the state to get additional federal money to pay for health care programs.

51 Is there more than one car in the children's household? ❑ Yes ❑ No

52 Is there more than $3,150 cash in bank accounts in the children's household? ❑ Yes ❑ No

SECTION 8: Signature and Certification.

53 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, the declarations made, and the documents submitted are true and correct to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature _____ Date: _____

Witness Signature _____ Date: _____
(If person signed with a mark)

Authorized Representative *(If any)* _____ Date: _____

SECTION 9: Fill in ONLY if you have been helped by a Certified Application Assistant (CAA).

54 If you would like information released to a CAA, check this box:

❑ By checking this box and signing below, I give my permission for **Healthy Families** and **Medi-Cal** to give information over the telephone about the status of this Application to the representative of the Enrollment Entity organization identified below. This permission will end on the date the program mails the results of the eligibility determination on this Application.

55 I certify I had help completing this form by the Certified Application Assistant listed below. This CAA help was **FREE** of charge. CAA#: ☐☐☐☐☐☐☐☐☐☐ EE#: ☐☐☐☐☐☐

Applicant Signature: _____ Date: _____

CAA Signature: _____ Date: _____

The state will not issue a reimbursement to the enrollment entity unless this question is completely and correctly filled out at the time this Application Form is submitted.

TEAR HERE

If it appears you qualify for **Healthy Families** and want to choose your health, dental and vision plan now, fill out this page. Otherwise, we will contact you later for this information. See your **Healthy Families Handbook** for more information, or visit our web site at **www.healthyfamilies.ca.gov**.

SECTION A: Health, Dental and Vision Plan Choices.

56 Health Plan/Code	57 Dental Plan/Code	58 Vision Plan/Code

59 Name of Doctor/Clinic *(optional)*	60 Doctor/Clinic Code *(optional)*	61 Name of Dentist/Clinic *(optional)*	62 Dentist/Clinic Code *(optional)*

SECTION B: Rural Demonstration Project.

63 If you are in any of these groups, there is a new statewide health, dental and vision plan combination offered to you. You can pick this new combination and put the code in the box below. See the **Healthy Families Handbook** for the combination code number.

Check all boxes that apply to you.

❑ Native American Indian **OR** Working in seasonal or migratory jobs: ❑ Agriculture ❑ Forestry ❑ Fishing

Plan Combination Code

SECTION C: Healthy Families Declarations

I declare that each person I am applying for:

- is a resident of California.
- is not in jail or in a mental hospital.
- is not eligible for Medicare Part A and Part B.
- is not a member of a family that is eligible for health benefits from the California Public Employees Retirement System Health Benefits Program(s).

I further declare that:

- all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating plans in which the individual is enrolled.
- I have read and understand the **Healthy Families Handbook**. I understand what it says about each health, dental and vision plan and the benefits they offer.
- I am applying for all of my children eligible for **Healthy Families**, unless they are already enrolled, or I am 18 years old or a minor and applying for myself.
- I agree to pay 6 monthly premiums. If I do not pay the premiums, I will be taken off the program and cannot participate again for 6 months. I will have to pay for any **Healthy Families** services I use in the last month after coverage ended.
- I give permission to **Healthy Families** to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this application.
- I agree to notify the program within 30 days of any change of address of any person applied for who is accepted into the program and any change in the applicant's billing address.

SECTION D: Privacy Notice.

The Information Practices Act of 1977 and the Federal Privacy Act require the **Healthy Families** Program to provide the following notice to individuals who are asked by **Healthy Families** to supply information:
Personal and medical information requested is for subscriber identification and program administration purposes only. Program regulations under Title 10, CCR, Section 2699.6600 require that every individual furnish certain information when applying to the **Healthy Families** Program. Subscriber's information may be shared with State and local agencies involved in the administration of health programs. Information (including immigration status) about persons who do not become subscribers, will be used only for purposes of eligibility determination and program administration. Failure to furnish this information may result in the return of the application as incomplete.
The following information on the application is not mandatory: social security number, ethnicity information (unless the subscriber is a Native American Indian) and any other item marked voluntary or optional. An individual has a right to access records containing his/her personal information that are maintained by the Managed Risk Medical Insurance Board. The official responsible for maintaining the information is the Deputy Director of Eligibility and Enrollment, Managed Risk Medical Insurance Board, 1000 G Street, Room 450, Sacramento, California 95814, (916) 324-4695.

SECTION E: Resolving Disputes.

If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. The **Healthy Families Handbook** has information about each plan and the arbitration requirements. You may call the plans you choose to find out more.

SECTION F: Signature and Certification.

64 **I certify** that I have read and understand the information above. **I also certify** that the information I have given on this form is true and correct.

Signature _____ Date _____

Witness Signature _____ Date _____
(If person signed with a mark)

APPLICATION INSTRUCTIONS

SECTION 2 Continued

Question 23

Write the place of birth for each child or pregnant woman. If born in California, write the name of the county. If born outside of California, write the name of the state. If born outside the United States, write the name of the country.

Question 24

Use the chart below to find the ethnic code number or letter to answer Question 24. Giving an ethnic code is optional unless Native American Indian.

Ethnic Codes

1	White	A	Amerasian	N	Asian Indian
2	Hispanic	C	Chinese	P	Hawaiian
3	Black/African American	H	Cambodian	R	Guamanian
4	Asian	J	Japanese	T	Laotian
5a	Native American Indian	K	Korean	V	Vietnamese
5b	Alaskan Native	M	Samoan	Z	Other
7	Filipino				

Question 25

- Immigration information we get as part of this application is private and confidential. The State will use this information only for eligibility determination and program administration. (See Privacy Notifications.)

Medi-Cal and **Healthy Families** do not collect information on the immigration status of parents/guardians who are not seeking health coverage for themselves. These programs cannot and will not provide information on the immigration status of such parents to the INS or use immigration information to demand or collect repayment from recipients for services lawfully received.

- Give immigration information **only for** the people applying for health coverage. Do not give information for people (such as parents) who are not applying.
- Many immigrants can qualify for **Healthy Families** and **Medi-Cal**.

  For **Healthy Families**: children must be eligible qualified aliens. The **Healthy Families Handbook** explains which aliens may be eligible and lists different types of immigration status.

  For **Medi-Cal**: undocumented children and pregnant women can get pregnancy-related and emergency services. Immigrants who meet all income and immigration requirements can get **complete Medi-Cal benefits**.

Question 26

- Social Security numbers **are not required** for **Healthy Families** or for persons who want **Medi-Cal** for emergency or pregnancy related services only.
- The Social Security number of each child, teen or pregnant woman applying for **complete Medi-Cal benefits** is required.
- If you do not have a Social Security number and want **complete Medi-Cal benefits**, you can apply now and provide the number within the next 60 days.
- For more information on how to apply for a Social Security number, please call the Social Security Administration **toll-free, 1-800-772-1213**.

Question 27

Write the name of the mother of each child and/or the pregnant woman. If the mother is the same for all children, write her name for child 1, write "same" for the other children and/or pregnant woman.

Question 28

Write the name of the father of each child and/or the pregnant woman. If the father is the same for all children, write his name for child 1, write "same" for the other children and/or pregnant woman.

Question 29

Write the name of the spouse of the teen if the spouse is living in the home. Write the name of the pregnant woman's husband if her husband is living in the home.

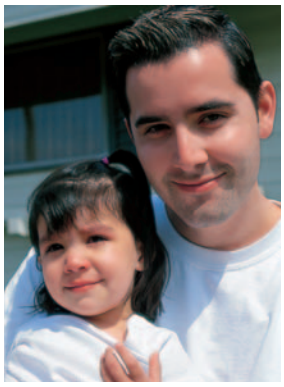
Question 30

If the child had or now has **no-cost Medi-Cal** and the county sent a notice stating that the child now has or will have **Medi-Cal with some cost**, check "yes". Give the date the **no-cost Medi-Cal** coverage will end for each person. If the answer is "no", check "no".

Questions 31 and 32

- For **Medi-Cal**: You can get **no-cost Medi-Cal** and still have other health coverage. **Medi-Cal** may cover what your other insurance does not.
- For **Healthy Families**: Your child will not be eligible for **Healthy Families** if he/she has employer-sponsored health insurance.

SECTION 3



Family members living in the home. Family size is used to determine which program your children are eligible for.

Who counts as an adult family member?

- natural or adoptive parents of the child who would get benefits
- husband of the pregnant woman applying
- pregnant woman
- emancipated minor or minor living on their own and self supporting

Who counts as natural and adoptive children?

- unborn child
- all children under age 21 living in the home
- all children under age 21 away at school and claimed as tax dependents

Do not count family members who get public assistance such as **SSI/SSP** or **CalWORKs**.

Question 33

Children under 21 years of age living in the home are counted as family members in family income calculation. **For example:** if there are two children listed in Section 2 and two children listed in Section 3, we may be able to count four children in the home instead of two. List the brothers, sisters, stepbrothers, stepsisters in the home who are not listed in Section 2, Question 17 (child 1, child 2, child 3 or child 4).

Question 34

Prenatal care is important for all pregnant women. The answer to this question will help a **Medi-Cal** program representative identify pregnant women's applications and process them faster.

Question 35

The answer to this question will help us figure your correct family income.

Question 36

Check "yes" if a brother/sister, stepbrother/stepsister between the ages of 19-21, or a parent or stepparent want **Medi-Cal** coverage. If you check "yes", you will be contacted for more information.

SECTION 4

List income of all persons in Section 2 and 3 who live in the home. This information is used to determine which program you are eligible for.

Question 37

Use a separate line for each person who gets income. If a person gets income from two different sources, use two lines. **For example:** If Maria has two jobs, use one line for each job to report her earnings.

Question 38

List where the income comes from. **For example:** income could come from work (employer or self employment); child support from a parent who is not in the home; alimony from an ex-spouse; benefit payments from government agencies such as Social Security Retirement Survivor Disability Insurance and Veterans Administration; insurance policies; pension funds; rental properties; and gifts from relatives and friends, etc. If you have questions about what income to list, please call **toll-free, 1-800-880-5305**.

Do not list as income SSI/SSP payments; foster care payments for foster children in your care; college work study; CalWORKs payments (replaces AFDC); loans; and earnings of a child under age 14 or who goes to school.

Question 39

How often is this income received?
For example: once-a-week (weekly), every two weeks, two times a month, once a month, once a year, etc.

Question 40

- Write the amount of income you get each time. **For example:** if the income is received once a week, write the weekly amount in the box.
- If the income amounts change from time to time, put the average amount received on a regular basis. We will use the paystub or other document you give us to figure out the correct monthly income.
- If you know your family's income will go up or down **in the next few months** due to overtime, promotion, raises in pay, expected increases in child support/alimony, layoffs, furloughs, etc., explain on a separate sheet of paper. **For example:** Maria's income from her job this month is $1000 but her regular monthly pay is only $800. Explain on the paper that Maria's paycheck included $200 overtime pay (or a $200 bonus), and how long the overtime will last (how often she gets bonuses).
- If self-employed, write the net profit from Schedule C of last year's federal income tax return. Or give the last 3 months' profit and loss statements.
- If using last year's federal income tax return, add all income amounts reported. Do not deduct losses.

Question 41

- Social Security numbers are optional for this question.

SECTION 5

Deductions From Family Income.

The answers in this section help us determine what amounts we will use to lower your family's monthly income.

Question 42

We will deduct payments for court-ordered **child support or alimony** from the family's income.

Question 43

Write the name of the person who pays the child support or alimony.

Question 44

Write in the total amount the parent of the child or spouse of the pregnant woman (listed in Section 2) pays in one month for child support or alimony.

Question 45

Write in the name of each person receiving child care or dependent care.

Question 47

Write in the total amount that is paid in one month for each child or disabled dependent.

We will deduct payments for **child care and/or disabled dependent care** from the family's income if:

- the payments are made by a parent of the child or spouse of the pregnant woman (listed in Section 2); and
- the parent of the child or spouse of the pregnant woman (in Section 2) is working or in job-training and no one in the home can provide care.

We will not deduct more than the maximum allowed for each child's care or disabled dependent's care. Maximums depend on the age of the person receiving care.

Monthly maximum deductible amounts for each child and disabled dependent are:

Child under the age of 2	**= $ 200**
Child age 2 and older	**= $ 175**
Disabled dependent of any age	**= $ 175**

WORK EXPENSE DEDUCTIONS

Up to a $90 deduction will be given for each person in your family listed in Section 4 working or receiving State Disability Insurance or Workers Compensation.

CHILD SUPPORT AND ALIMONY DEDUCTIONS

If you get income from child support or alimony, a $50 deduction from your family income will be made.

SECTION 6

Other Coverage.

Question 48

If **Medi-Cal** pays for medical services you need because of accident or injury, the costs may be taken out of the lawsuit settlement if you received money.

Question 49

Medi-Cal may be able to help pay for some unpaid medical expenses you have had in the 3 months before you completed this application.

- Even if you are applying for **Healthy Families** and have unpaid medical expenses in the 3 months before you completed this application, **Medi-Cal** may be able to help.
- If you check "yes", a **Medi-Cal** representative will call you for more information.

Question 50

If the child in Section 2 gets enrolled in **no-cost Medi-Cal**, and your income goes up in the future, or your status changes, we will send your application to **Healthy Families**. If you do not want your application to be sent to **Healthy Families**, check this box.

SECTION 7

Voluntary Information.

Questions 51 and 52

You do not have to answer these questions.

SECTION 8

Signature and Certification.

Question 53

State and federal laws require your signature on this application form. Your signature in this section indicates that your declarations and answers are truthful and the documents you submit are true and correct.

SECTION 9

Application Assistance.

Question 54

By checking the box, you give **Healthy Families** and **Medi-Cal** permission to give information over the phone about the status of the Application Form to a representative of the Enrollment Entity (EE) listed. This permission will end on the date the program mails the results of the eligibility determination on this Application.

Question 55

You are declaring that you have been helped by the CAA so the programs can reimburse the EE for helping you.

FILLING OUT THE HEALTHY FAMILIES PAGE

Questions 56 through 64

Answer these questions if your children appear to be eligible for **Healthy Families** and you want their health coverage to begin as soon as possible. Otherwise, we will contact you later for this information. The **Healthy Families Handbook** has important information about the program, the plans in your county, selecting a doctor or dentist and premium payments. Use the **Handbook** to select a health, dental and vision plan.

Send your first month's premium payment with the application, pages A1-A4. If you pay premiums for 3 months at one time now, your fourth (4th) month is **FREE!** Make your premium payment payable to the **Healthy Families** Program. Personal checks, money orders and cashier's checks are fine. Sorry, we do not accept cash. See the **Healthy Families Handbook** to find out what your monthly premium will be. If your child is not eligible for **Healthy Families**, your premium payment will be refunded to you.

To request a copy of the **Healthy Families Handbook**, please **call toll-free, 1-800-880-5305**. **Visit our web site at www.healthyfamilies.ca.gov**.

WHAT DOCUMENTS ARE NEEDED

- **A copy of the birth certificate** for any U.S. citizen or national applying for health coverage. Send it now or within 60 days of enrollment.

  OR

  Proof of immigration status or a receipt from the INS showing you have applied to replace a lost document. Only persons seeking health coverage should send a copy of the document showing date of entry (both sides) or receipt now or within 30 days of enrollment. If the child or pregnant woman does not have any immigration documents, he/she may still be eligible for emergency or pregnancy related **Medi-Cal** services.
- **Proof of the deductions** listed in Section 5. For child care and dependent care, send receipts or cancelled checks.
- **Proof of California residency**. You can use your proof of income as proof of residency, too. If your income is not from California, send other proof of residency.
- If pregnant, or applying for an unborn child, **proof of pregnancy** from a doctor or clinic.
- **Proof of income**. Send a copy of the most recent paystub. If a paystub is not available, get a signed statement from employer. Gross monthly income and the dates received should be on the statement.

  OR

  Send a **copy of last year's federal income tax return**.

Other proof of income you may need to send:

- If a person is self-employed, send last year's federal income tax return (with a Schedule C) or the last **3 months' profit and loss statements**.
- If a person has income such as **disability or retirement**, send **copies of award letters or bank statements** showing the direct deposits.
- If anyone gets **child support and/or alimony** or spousal support, send **copies of the checks** received or **statements from the District Attorney's Family Support Division**, for the last month.
- For **Healthy Families** only: A **Medi-Cal "Share-of-Cost Notice of Action"** received in the last 30 days which shows the child has share-of-cost, may be used as proof of income.

Medi-Cal Confidentiality Notice:

The information given in this application is private and confidential under Welfare and Institutions Code Sections 10850 and 14100.2. The information will be disclosed only in accordance with those laws.

Medi-Cal Rights, Responsibilities and Declarations:

I have the right to:

- be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- ask for an interpreter.
- ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action". To find out about Medi-Cal fair hearings, call **toll-free, 1-800-952-5253**.

I have the responsibility to:

- send in a status report when the county asks me to.
- report any changes within 10 days in the information I gave on this application.
- let the county know if a family member: applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- cooperate if my case is reviewed.

I declare that each person I am applying for:

- lives in California.
- is not getting public assistance from outside California.
- is not in jail, prison, or any other correctional facility.

I further declare that:

- I understand that as a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
- If I am not eligible for this Medi-Cal program, I understand I may qualify for other programs and have the right to apply for them.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.

Medi-Cal Privacy Notice:

The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Services to provide the following information: Welfare and Institutions Code section 14011 and regulations in Title 22, CCR, require applicants for the Medi-Cal program to provide the eligibility information requested in this application. This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except in cases of fraud.) The information will be used by Electronic Data Systems to process claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application.

Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional. Social Security Numbers are required by Section 1137(a)(1) of the Social Security Act and by Welfare and Institutions Code Section 14011.2, unless applying for emergency or pregnancy related benefits only.

An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Services. Contact your county health and human services/ social services office to request your records.

For Help In Your Language...Please Call Toll-Free, 1-800-880-5305

For English information, Press 1. . . . . 1 English

Si desea información en español, oprima el 2. . . . . 2 Spanish

Muốn được giúp đỡ bằng tiếng Việt, xin gọi số trên và Bấm số 3. . . . . 3 Vietnamese

សម្រាប់ពត៌មានបន្ថែមជាភាសាខ្មែរ, សូមទូរស័ព្ទទៅលេខខាងលើហើយចុចលេខ 4. . . . . 4 Cambodian

Yog koj xav paub xov ntxiv hais ua lus Hmoob, thov koj hu tus xov tooj teev los saum toj no, tom qab ntawd, koj mam nias tus nabnpawb 5 . . . . 5 Hmong

Հայերենով տեղեկություն ստանալու համար խնդրում ենք հեռաձայնեք վերը նշված համարով եւ սեղմեք 6. . . . . 6 Armenian

如需粵語資料，請撥上列號碼並按 7. . . . . 7 Cantonese

한국어로 된 정보를 원하시면, 위에 나온 번호로 전화하신 다음 (8) 을 누르십시오. . . . . 8 Korean

Для получения информации на русском языке звоните, пожалуйста, по вышеуказанному телефону и нажмите кнопку 9. . . . . 9 Russian

برای کسب اطلاعات به زبان فارسی با شماره فوق الذکر تماس بگیرید و شماره 0 را فشار دهید. . . . . 0 Farsi

Provided by the State of California